

Bridge Administration Manual (COMDT INST M16590.5).<sup>3</sup> The FHWA policy on alternates, Alternate Design for Bridges; Policy Statement, was published at 48 FR 21409 on May 12, 1983.

#### § 650.809 Movable span bridges.

A fixed bridge shall be selected wherever practicable. If there are social, economic, environmental or engineering reasons which favor the selection of a movable bridge, a cost benefit analysis to support the need for the movable bridge shall be prepared as a part of the preliminary plans.

[FR Doc. 87-16997 Filed 7-27-87; 8:45 am]

BILLING CODE 4910-22-M

### POSTAL RATE COMMISSION

#### 39 CFR Part 3001

[Docket No. MC87-3; Order No. 768]

#### Amendment to Domestic Mail Classification Schedule; Extension of Collect on Delivery Services, 1987

Issued July 23, 1987.

**AGENCY:** Postal Rate Commission.

**ACTION:** Final rule.

**SUMMARY:** In accordance with the July 7, 1987, adoption of the Postal Rate Commission's recommended Docket No. MC87-3 decision by the Governors of the Postal Service, the Commission is publishing the corresponding changes for the Domestic Mail Classification Schedule (DMCS). The DMCS is found as Appendix A to Subpart C of the Commission's rules of practice and procedure (39 CFR 3001.61 through 3001.68). This change permits use of Collect on Delivery (C.O.D.) service in conjunction with items sent as Express Mail.

**EFFECTIVE DATE:** July 26, 1987.

**ADDRESSES:** Correspondence should be sent to Charles L. Clapp, Secretary of the Commission, 1333 H Street NW., Suite 300, Washington, DC 20268 (telephone: 202/789-6840).

**FOR FURTHER INFORMATION CONTACT:** David F. Stover, General Counsel, 1333 H Street NW., Suite 300, Washington, DC 20268 (telephone: 202/789-6820).

**SUPPLEMENTARY INFORMATION:** On July 7, 1987, the Governors of the Postal Service approved a decision (Docket No. MC87-3) of the Commission recommending a change in sections 500.090 and 6.020 of the Domestic Mail Classification Schedule (DMCS). The

effective date for the change is July 26, 1987. These sections set out the classes of mail for which C.O.D. service can be used.

On March 30, 1987, the Postal Service initiated a proceeding, pursuant to 39 U.S.C. 3623, requesting that the DMCS be amended to extend C.O.D. service to Express Mail. C.O.D. service has been available for mail pieces sent as First Class, single-piece third class and fourth class. The Postal Service explained that it had received requests from its customers to extend the use of C.O.D. service for mail pieces sent as Express Mail.

The Commission invited interested parties to comment and participate in the proceedings. 52 FR 10962 (April 6, 1987). The parties submitted a unanimous settlement, and agreed upon the material to be entered into the evidentiary record. On May 26, 1987, the Commission issued a decision recommending the change.

The amendment to the DMCS which is published in this order reflects the Governors' July 7, 1987, decision. Consistent with the Commission's explanation in the rulemaking (Docket No. RM85-1) which led to the publication of the DMCS in the *Federal Register*, this addition is published as a final rule, since procedural safeguards and ample opportunities to have different viewpoints considered have already been afforded to all interested persons.

#### List of Subjects in 39 CFR Part 3001

Administrative practice and procedure, Postal Service.

### PART 3001—RULES OF PRACTICE AND PROCEDURES

#### Subpart C—Rules Applicable to Requests for Establishing or Changing the Mail Classification Schedule

##### List of Changes

1. The authority citation for 39 CFR Part 3001 continues to read as follows:

**Authority:** 39 U.S.C. 404(b), 3603, 3622-3624, 3661, 3662, 84 Stat. 759-762, 764, 90 Stat. 1303; (5 U.S.C. 553), 80 Stat. 383.

2. The following change in the Domestic Mail Classification Schedule published as Appendix A to Subpart C (39 CFR 3001.61 through 3001.68) of the Commission's rules of practice and procedure is adopted:

(A) Add a new subsection c to section 500.090 to read as follows:

c. C.O.D. .... SS-6

(B) Add a new subsection d to section 6.020 to read as follows:

d. Express Mail. .... 500

By the Commission.

Charles L. Clapp,  
Secretary.

[FR Doc. 87-17054 Filed 7-27-87; 8:45 am]

BILLING CODE 7715-01-M

### ENVIRONMENTAL PROTECTION AGENCY

#### 40 CFR Part 61

[AD-FRL-3238-5]

#### National Emission Standards for Hazardous Air Pollutants; Standard for Radionuclides

**AGENCY:** Environmental Protection Agency (EPA).

**ACTION:** Technical amendment.

**SUMMARY:** Final rules for National Emission Standards for Hazardous Air Pollutants; Standards for Radionuclides were published in the *Federal Register* on February 6, 1985, 50 FR 5190. These included the following source categories: Department of Energy (DOE) facilities, Nuclear Regulatory Commission (NRC) licensed facilities and non-DOE Federal facilities, and elemental phosphorus plants. The action being accomplished today announces that the information collection requirements contained in 40 CFR Part 61, Subpart K regarding elemental phosphorus plants, which were under review by the Office of Management and Budget (OMB) at the time of promulgation, have now been approved.

**EFFECTIVE DATE:** The information collection requirements contained in 40 CFR 61.123, 61.124, 61.125, and 61.126 and as they apply to elemental phosphorus plants, 61.07, 61.09, 61.10, 61.13 have been approved by the Office of Management and Budget (OMB) and are now effective as of July 28, 1987.

**FOR FURTHER INFORMATION CONTACT:** Terrence A. McLaughlin, Chief, Environmental Standards Branch, Criteria and Standards Division, Office of Radiation Programs, U.S. Environmental Protection Agency (ANR-460), Washington, DC 20460, (202) 475-9610.

#### SUPPLEMENTARY INFORMATION:

In the preamble to the National Emission Standards for Hazardous Air Pollutants: Standard for Radionuclides, 40 CFR 61, February 6, 1985, 50 FR 5190, EPA noted that the information collection requirements were under review at the Office of Management and Budget (OMB). In accordance with the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 et seq.), those provisions are

<sup>3</sup> United States Coast Guard internal directives are available for inspection and copying as prescribed in 49 CFR Part 7, Appendix B.

not effective until OMB approval has been obtained. OMB approved the information collection requirements of Subpart K on June 12, 1985; accordingly, the Agency is now including the OMB control number in the body of the rule.

Subpart K includes requirements that elemental phosphorus plants test their emissions to show compliance with 40 CFR Part 61. With this notice informing the regulated community that OMB approval has been granted, the testing requirements of 40 CFR 61.123, 61.124, and 61.125 are now in effect.

Dated: July 16, 1987.

Don R. Clay,

Deputy Assistant Administrator.

#### PART 61—[AMENDED]

The following language is added at the end of §§ 61.123 through 61.126: "(Approved by the Office of Management and Budget under Control Number 2060-0117)"

[FR Doc. 87-16949 Filed 7-27-87; 8:45 am]

BILLING CODE 6560-50-M

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

##### Health Care Financing Administration

##### 42 CFR Parts 400 and 447

[BERC-275-FC]

##### Medicaid Program; Revisions to Medicaid Payments for Hospital and Long-Term Care Facility Services

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Final rule with comment period.

**SUMMARY:** This final rule makes several changes to the regulations governing Medicaid payments for hospital and long-term care facility services. These changes are intended cumulatively to promote increased economy in the administration of the Medicaid program while retaining State flexibility to the maximum extent possible.

**EFFECTIVE DATE:** With the exception noted below (§ 447.253(b)), these regulations are effective October 26, 1987. (See section V.A. of the preamble concerning information collection requirements.)

**Comment period:** Although these regulations are final, we will consider comments on the change we made to 42 CFR 447.272 regarding the exception to the upper payment limit for hospitals that serve a disproportionate number of low income patients with special needs. Comments will be considered if they are received at the appropriate address, as

provided below, no later than 5:00 p.m. on September 28, 1987.

**ADDRESS:** Mail comments to the following address:

Health Care Financing Administration,  
Department of Health and Human  
Services, Attention: BERC-275-FC,  
P.O. Box 26676, Baltimore, Maryland  
21207

If you prefer, you may deliver your comments to one of the following addresses:  
Room 309-G, Hubert H. Humphrey  
Building, 200 Independence Ave., SW.,  
Washington, DC.,

or

Room 132, East High Rise Building, 6325  
Security Boulevard, Baltimore,  
Maryland.

In commenting, please refer to file code BERC-275-FC. Comments received timely will be available for public inspection as they are received, generally beginning approximately three weeks after publication of a document, in Room 309-G of the Department's offices at 200 Independence Ave., SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5:00 p.m. (phone: 202-245-7890).

**FOR FURTHER INFORMATION CONTACT:** Janet Wellham, (swing-bed provisions), (301) 597-1939, or Tzvi Heftler (all other provisions), (301) 597-1808.

#### SUPPLEMENTARY INFORMATION:

##### I. Background

On February 18, 1986 we published a notice of proposed rulemaking (NPRM or proposed rule) in the *Federal Register* (51 FR 5728) to amend 42 CFR Part 447, Subparts C and D governing Medicaid payments for inpatient hospital and long-term care facility services and payment methods for other institutional and noninstitutional services. The provisions of the proposed rule, the comments we received and the changes we made in response to those comments are discussed below.

##### II. Proposed Rule

###### A. Submittal of Assurances

Section 1902(a)(13)(A) of the Social Security Act (the Act) (42 U.S.C. 1396a(a)(13)(A)), as amended by section 2173 of the Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35), enacted on August 13, 1981, requires that a State must find and provide satisfactory assurances to HCFA that its Medicaid payments for inpatient hospital and long-term care facility services are made through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically

operated facilities. The assurances must provide that the State's payment rates are set at a level that allows facilities to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. Our current regulations at 42 CFR 447.253(b) require the State agency to submit assurances to HCFA whenever the agency makes a significant change in its methods and standards for determining payment rates for inpatient hospital and long-term care facility services. In the February 18, 1986 NPRM, we proposed to revise § 447.253(b) to require State agencies to submit assurances and related information for all changes in the methods and standards used for determining payment rates.

###### B. Inappropriate level of care services

Section 1902(a)(13)(A) of the Act also requires Medicaid reimbursement to reflect the actual level of care received by hospital inpatients specifically including when the patient is receiving "inappropriate level of care" services. For purposes of this section, the term "inappropriate level of care" means the level of care furnished to individuals who are hospital inpatients but who require only a skilled nursing or intermediate level of care and an SNF and ICF bed is not available.

Currently, a State's coverage for inappropriate level of care services is optional. A state may elect not to cover inappropriate level of care services since the care is provided in an inappropriate setting. However, if a State has chosen to cover this care, payment must be reduced to reflect the level of care required by the patient.

Section 1902(a)(13)(A) of the Act requires that payment of inappropriate level of care must be made in a manner that is consistent with section 1861(v)(1)(G) of the Act, which governs Medicare payment for SNF services received in a hospital, if a SNF bed is not available. Since there are no implementing regulations for this Medicare provision, the reference to that section in section 1902(a)(13)(A) of the Act has been confusing to States. In order to eliminate this confusion, we proposed a revision to § 447.253(b)(1)(ii). We clarified that if a State covers inappropriate level of care services, it must find and assure HCFA that its methods and standards used for determining payment rates result in reduced Medicaid inpatient payments, consistent with Medicare principles for patients receiving this level of care.

### C. Upper Payment Limit

Section 1902(a)(30) of the Act (42 U.S.C. 1396a(a)(30)) requires that the State plan methods and standards used to determine payment rates result in payments that are consistent with efficiency, economy and quality of care. Section 447.253(b)(2) of our current regulations requires that the Medicaid agency assure HCFA that it has estimated that under its proposed average payment rate the State will not pay more in the aggregate for inpatient hospital services or long-term care facility services than the amount that would have been paid for the services under the Medicare principles of payment. In the NPRM, we proposed to revise § 447.253(b)(2) to state that an agency must assure HCFA that it has found that its proposed payment rate will not exceed the upper payment limits specified in the new § 447.272.

The proposed § 447.272 provided that payments by a State agency for inpatient hospital services or long-term care facility services to hospitals, SNFs, ICFs or ICFs for the mentally retarded (ICFs/MR) could not exceed the amount that could reasonably be estimated would have been paid for the services under Medicare payment principles in effect at the time the services were furnished. This section further provided that if a State used a separate ratesetting methodology within these categories of facilities, then the upper payment limit would have to have been applied to the payments to each group of facilities paid under each of the separate ratesetting methodologies.

We also proposed to revise § 447.321 in subpart D to clarify that the upper payment limit for outpatient services is calculated based on total payments received by all providers, which results from determining the payments made to individual providers during the period.

### D. Federal Financial Participation Payments

Section 1903(a)(1) of the Act (42 U.S.C. 1396b(a)(1)) provides that Federal financial participation (FFP) is available to match only the expenditures incurred in providing medical assistance under the State plan. In accordance with section 1902(a)(13)(A) of the Act (42 U.S.C. 1396a(a)(13)(A)), a State's payment rates must be reasonable and adequate to meet the costs incurred in the provision of care and services. In the NPRM, we proposed to add a new § 447.257 to specify that FFP is not available for any payment by an agency that is in excess of the amounts allowed under Medicare regulations governing payments for inpatient hospital and

long-term care facility services. A State, in setting its payment rates, must consider only those factors that are specifically applicable to the provision of covered care and services to Medicaid patients.

### E. Swing-Beds

In the NPRM, we proposed to revise § 447.280, which deals with payments to hospitals for SNF and ICF services provided in swing-beds. We proposed to provide States with greater flexibility in setting payment rates for SNF and ICF services provided by swing-bed hospitals. We proposed to give States the option to pay for these services at either the average rate per patient day paid to SNFs or ICFs (other than ICFs/MR) in the State for services furnished during the previous calendar year or at a rate established by the State. We stated that if the State chooses to establish its own rate for SNF or ICF services furnished in a swing-bed, we would require that the rate meet the State plan and payment requirements described in 42 CFR Part 447, Subpart C, as applicable (that is, those assurances and related information requirements that are appropriate for swing-bed services.) Finally, we stated that the State must apply whichever payment method it chooses to all swing-bed hospitals in the State. This revision to § 447.280 is necessary in order to conform our regulations to section 1913(b)(3) of the Act, as enacted by section 2369 of the Deficit Reduction Act of 1984 (Pub. L. 98-369), enacted on July 18, 1984.

### III. Responses to Comments and Changes From the Proposed Rule

We received timely comments on the proposed rule from 43 commenters, including States, State associations, individual hospitals and others representing hospitals and long-term care facilities. These comments and our responses to them are discussed below.

**Comment:** A number of State agencies commented that the proposed requirement to submit assurances and related information for all changes to a State's methods and standards for determining payment rates would be burdensome. One commenter stated that the requirement to submit assurances for all changes would put States at risk and would require States to use public notice procedures for all changes. Another commenter was of the opinion that assurances would also be required for outpatient services.

**Response:** Our current regulations (§ 447.253(b)) require that a State agency submit assurances and related information supporting its assurances whenever the agency makes a

significant change to its methods and standards for establishing payment rates for inpatient hospital services and long-term care facility services. We have found that, in many cases, the basis for a State's determination of whether a change is significant or not significant is unclear or unsupported or both. A State's basis for a determination of the significance of a plan change can affect HCFA's determination of the effective date of the change or of the adequacy and the reasonableness of the rates resulting from the change.

At the time § 447.253(b) was issued (September 30, 1981), we presumed that a State's determination of the significance of a change would be based on the estimated impact of the change on providers within the State. However, based on our experience since that regulation was published, it has become apparent to us that a State's determination of non-significance is often based on the State's desire to preserve the effective date of a proposed change. Section 447.256 precludes the approval of an effective date for a State plan change prior to the first day of the quarter in which assurances and related information are submitted. Because assurances were required only for significant changes, a State could avoid having to comply with § 447.253(b) by designating a change as nonsignificant, thereby realizing an earlier effective date than might otherwise be allowed under § 447.256. (As part of this final rule, we made a technical conforming change in § 447.256 to delete the term "significant".)

The requirement to submit assurances and related supporting information for all plan changes should not be burdensome on the States. Based on our experience the vast majority of plan changes that have been submitted by States have been labeled as significant and have been accompanied by the required assurances and related information. In addition, a plan amendment that makes only procedural changes to the State's methods and standards, and that does not revise the computation of the rate payable to a facility, would not require the State to prepare and submit revised data in support of its assurances. Under these circumstances, the resubmission of applicable data prepared by the State for its most recently approved State plan would be acceptable, as would an assurance that the previously submitted data remain valid. Therefore, because most plan changes are already identified as significant or deal with procedural matters for which revised supportive data are not required, the number of

plan changes affected by this change in the regulations is small and will not create a burden on the States.

It should be noted that the deletion of the term "significant" in § 447.253(b) applies only to the submittal of assurances and related information for changes to a State's methods and standards for determining payment rates for inpatient hospital services and long-term care facility services. This change does not apply to hospital outpatient services and does not affect public notice requirements. Section 447.205 will continue to require public notice for changes that are significant. States will continue to decide what is significant for public notice purposes. We agree that a requirement mandating public notice for all changes would be impracticable because it would impose burdensome reporting requirements on States and would not facilitate HCFA's review of changes. The assurance required by § 447.253(f) regarding public notice continues to require States to assure that they have complied with the public notice requirements in § 447.205 for all significant changes to its method and standards for determining payment rates for inpatient hospital services and long-term care facility services.

**Comment:** A number of hospitals and their provider organizations commented on the proposed clarification of HCFA's policy concerning lower Medicaid payments to hospitals for inappropriate level of care services. These commenters stated that hospitals should not be penalized for a lack of available SNF or ICF beds. They believe that State programs should have the flexibility to pay rates necessary to cover the costs of providing care for patients. Some commenters were concerned with the effect of the application of the excess bed provision, specified in section 1861(v)(1)(G) of the Act (42 U.S.C. 1395x(v)(1)(G)) to Medicaid reimbursement.

**Response:** The proposed change to § 447.253(b)(1)(ii)(B) is merely a clarification of existing provisions of the statute and regulations. We did not propose a change in policy, and the clarification in no way has the effect of penalizing hospitals. Section 1902(a)(13)(A) of the Act provides for the payment of lower reimbursement rates, "in a manner consistent with section 1861(v)(1)(G) of the Act," for hospital patients receiving services at an inappropriate level of care. Inappropriate level of care, as the phrase is used in the statute and as discussed above, means the level of care furnished to individuals who are hospital inpatients but who are

receiving only a SNF or ICF level of services.

The legislative history of section 1902(a)(13)(A) of the Act (H.R. Rep. No. 97-208, 97th Cong., 2nd Sess. 947 (1981)) explains that this provision was intended to allow a State to cover inappropriate level of care services provided in a hospital, if those services would not otherwise be available to the individual. Thus, coverage and lower payments for inappropriate level of care services are only allowable when there are no SNF or ICF beds available. It was not the intent of Congress that coverage be provided or payment for inappropriate care services be made if a hospital provides services at an inappropriate level of care when necessary care is available in the appropriate setting (that is, in a SNF or ICF). In these cases, no payment to the hospital is appropriate for services at an inappropriate level of care.

As noted, section 1902(a)(13)(A) of the Act requires that the Medicaid payment rates for inappropriate level of care services conform to the Medicare payment requirements in section 1861(v)(1)(G). As a result, § 447.253(b)(1)(ii)(B) of the regulations has specifically required that the methods and standards used by a State agency to determine Medicaid payment rates must provide that payment for hospital inpatients receiving services at an inappropriate level of care under conditions similar to those described in section 1861(v)(1)(G) of the Act must be made at lower rates, reflecting the level of care actually received in a manner consistent with that section of the Act.

While the reference to section 1861(v)(1)(G) of the Act, in section 1902(a)(13)(A) clearly requires that payment for Medicaid inappropriate level of care services be at a lower rate than the full inpatient hospital rate, section 1861(v)(1)(G) of the Act provides an exception to this general rule. If there is not an excess of hospital beds in the hospital providing the care and there is not an excess of hospital beds in the area of the hospital, then payment may be made at the regular rate for inpatient hospital services payable under Part A of Medicare, rather than at the reduced rate.

We noted in the proposed rule that the references in the Medicaid statute and in § 447.253(b)(1)(ii)(B) to section 1861(v)(1)(G) of the Act have caused some confusion as to which Medicare requirements States must consider when providing coverage for inappropriate level of care services. Section 1902(a)(13)(A) of the Act requires that in situations similar to those described in

section 1861(v)(1)(G) of the Act the payment rate must be reduced. Since the statute addresses conditions *similar* to the Medicare conditions described in section 1861(v)(1)(G) of the Act, we have given States the option of adopting the excess bed exclusion contained in section 1861(v)(1)(G)(i) of the Act. However, we have not placed specific requirements on States concerning the relationship between the excess beds rule contained in section 1861(v)(1)(G) of the Act and the Medicaid program. States are not *required* under the Medicaid program to provide for the same excess bed exclusion as that required under Medicare. A State has the flexibility to develop its own excess bed exclusion to meet its needs. For example, States have the option of reducing their payment rates in all cases, even when there are no excess beds.

If a State wishes to pay the full inpatient hospital rate when there are no excess beds, it must establish criteria for determining that a hospital has no excess beds and that there are none in its area and incorporate these criteria into the State plan methodology. The criteria would have to be reasonable and consistent with section 1861(v)(1)(G) of the Act. As an operational guideline, HCFA has allowed an 80 percent occupancy threshold as an acceptable definition of hospitals with no excess capacity. However, other reasonable standards for establishing excess capacity could be acceptable. We are not mandating that States provide for an excess bed exception, nor are we prescribing parameters for criteria for the exclusion if a State chooses to adopt the excess bed exclusion.

**Comment:** Numerous commenters questioned HCFA's authority for implementing a Medicare upper payment limit. There were concerns raised regarding the application of the upper payment limit in the aggregate. In addition, the commenters questioned the use of the prospective payment system in computing the Medicare upper payment limit and how the Gramm-Rudman-Hollings Act (Pub. L. 99-177) affects Medicaid payments.

**Response:** The comments we received and other concerns raised by the public have demonstrated to us a need to revise and clarify the upper payment limit provision. Thus, as we proposed to do, we are adding a new § 447.272 to the regulations to explain the application of the upper payment limit. However, in response to the large number of comments received on this section, we

found it necessary to make revisions to what was proposed.

Section 1902(a)(30) of the Act (42 U.S.C. 1396a(a)(30)) requires that State plan methods and standards used to determine payment rates result in payments that are consistent with efficiency, economy and quality of care. This provision is the statutory basis for the requirement in the regulations that Medicaid payments be consistent with efficiency and economy and not exceed the amount that would be allowable by applying Medicare principles to Medicaid costs.

Section 962 of the Omnibus Reconciliation Act of 1980 (Pub. L. 96-499), effective on October 1, 1980, amended section 1902(a)(13)(A) of the Act to give States the flexibility to deviate from Medicare's cost payment principles, which many States believed to be inflationary, by deleting the requirement that State reimbursement methodologies be cost-related. However, although States were given the flexibility to adopt methodologies that were believed to be more economical and efficient than Medicare, Congress expressed its intent that payments under State Medicaid payment systems not exceed amounts paid by Medicare. (For example, see Senate Report 96-471, 96th Cong., 1st Sess. 28 (1979).)

The legislative history for section 2173 of Pub. L. 97-35 also indicates that Congress intended to impose an upper payment limit on State Medicaid payments. The conference committee report (H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 5708 (1981)) adopted the Senate version with a modification requiring States, in developing their payment rates, to take into account the situation of hospitals that serve a disproportionate number of low-income patients. The Senate version of the bill provided that State payments cannot in the aggregate exceed the amount determined to be reasonable under Medicare.

On December 19, 1983, we issued in the Federal Register (48 FR 56046) final regulations that implemented sections 1902(a)(13)(A) and 1902(a)(30) of the Act. These regulations incorporated an upper payment limit assurance into the procedures for review of inpatient hospital and long-term care facility payment State plan amendments. Consequently, § 447.253(b)(2) requires a State Medicaid agency to provide an assurance that its estimated average proposed payment rate for inpatient hospital services or long-term care facility services is reasonably expected not to exceed in the aggregate the amount that the agency reasonably

estimates would be paid for the services under the Medicare principles of payment. For example, in applying the upper payment limit for long-term care facilities, States should give consideration to the cost limits provided for in the newly redesignated § 413.30 (formerly § 405.460 but redesignated on September 30, 1986 (51 FR 34800)). For ICFs or ICFs/MR, for which there are no comparable Medicare rates, States should apply Medicare cost principles to Medicaid costs incurred in a given base year. In such a case, these costs would then be further adjusted by the Medicare market basket rate of increase from the base year through the year for which the rate is being determined in order to estimate what Medicare costs for the year would have been.

In applying the Medicare upper payment limit for inpatient hospital services provided prior to October 1, 1982, States are expected to apply Medicare's reasonable cost principles to Medicaid costs incurred in providing care to Medicaid patients. For payments for services provided on or after October 1, 1982, these Medicare reasonable cost principles are to be applied as modified by section 1886 (a) and (b) of the Social Security Act, as enacted by section 101 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97-248). Those amendments imposed rate-of-increase limits on Medicare payments. As modified, these principles are to be applied to Medicaid costs to determine the cost per discharge in a given base year and the Medicare rates of increase through the rate year would be applied to the Medicare determined cost per discharge to determine the adjusted Medicare cost in the rate year. This amount would then be compared to the actual Medicaid payment in the rate year.

Although under the Medicaid program States have the flexibility to adopt a prospective payment methodology based on diagnosis related groups (DRGs) (similar to that of Medicare), we recognize that, for purposes of computing an upper payment limit, it would be difficult for a State to attune its system to the Medicare prospective payment methodology. The Medicare system involves a combination of hospital-specific and Federal payment rates (with the latter being based on a blend of national and regional rates per discharge). Therefore, if a State has adopted or wishes to adopt a system using DRGs, the State's upper payment limit assurance can be based on the application of the Medicare principles, as modified by section 101 of Pub. L. 97-248, to Medicaid costs in a base year, and adjusted by the rate of increase

limits under sections 1886 (a) and (b) of the Act.

In the NPRM published on February 18, 1986, we proposed a change in the application of the upper payment limit because of the inherent ability of States to adopt separate payment methodologies for certain facilities with the object of maximizing payments to certain facilities. A State could pay one group of facilities less than actual costs incurred by that group of facilities while paying another group of facilities more than actual costs incurred with the latter amount being in excess of the amount payable under the Medicare principles but not exceeding the overall aggregate upper payment limit. The proposed § 447.272 would have continued to apply the Medicare upper payment limit in the aggregate to all facilities within each category of facility (that is, hospital, SNF, ICF, and ICF/MR). However, the proposed § 447.272 would have added a requirement that if a State differentiated its payment methodologies within these categories, the upper payment limit would have been applied in the aggregate to each group of facilities that were subject to a particular payment methodology. The arraying of facilities in different groups would not have constituted a different payment methodology. Although not specifically stated as such, this provision was intended to preclude a State Medicaid agency from paying State-owned or operated facilities more than would be payable under Medicare principles. However, in response to the comments received, we have decided that rather than changing the application of the upper payment limit as it is currently being applied to all facilities, we should limit our change to State-operated facilities.

The Medicaid program is a State/Federal program that provides FFP for specific State expenditures. Generally, it is in a State's best interest to adopt cost effective payments methodologies for reimbursing non-State operated facilities for medical assistance. The imposition of limits on the amounts payable to a facility to amounts that are reasonable and adequate to meet the costs of an efficiently and economically operated facility allows a State to regulate effectively its expenditures for hospital and long-term care services provided to Medicaid recipients. However, we believe that there are no similar incentives for the imposition of cost-constraining methodologies for State-operated facilities because the costs not considered reimbursable under Medicaid would be borne entirely by the State. Recognition of all (or almost all)

of the costs incurred in operating these facilities maximizes what the State will receive in FFP payments. In one State, for example, audits have found that the prospective payment system established for State-owned and operated ICFs/MR resulted in the State receiving over \$11 million more than actual allowable costs incurred by those ICFs/MR, while the payment methodology used for determining payment rates for private ICFs/MR resulted in payments to those facilities in amounts less than their costs. In another State, payments to State-operated long-term care facilities increased 100 percent over a nine month period. Although the increase appeared arbitrary, it was consistent with the regulations currently in effect. Even when a State has only one reimbursement system for all facilities of a given type, the State's differential application of that system to State-owned facilities can result in excessive payments to those facilities. Thus, in order to correct these situations, we believe it is in the best interest of the Medicaid program to revise the application of the Medicaid upper payment limit as it applies to State-operated facilities.

The new § 447.272, as issued in this final rule, will require a State Medicaid agency to provide separate assurances to HCFA regarding the upper payment limit. First, the State will be required to assure that in the aggregate payments for either inpatient hospital, SNF, ICF, or ICF/MR services, respectively, do not exceed the Medicare upper payment limit. This assurance is the same as was previously required. In addition, the State Medicaid agency will also be required to assure that payments to State-operated facilities when considered separately do not exceed the Medicare upper payment limit. Under the new § 447.272, the Medicare upper payment provisions will not be applied on a facility-specific cost basis, but will be applied in the aggregate. The upper payment limit will be applied as a limit on total costs incurred by all facilities within a specific category (such as hospitals, SNFs, ICFs or ICFs/MR).

The application of the upper payment limit does not require the application of the budgetary reductions mandated by the Gramm-Rudman-Hollings Act. The Medicaid program is specifically excluded from the budget reductions mandated by that Act.

We emphasize that the upper payment limit assurance required by § 447.253(b)(2) is a prospective assurance. The State is required to assure HCFA that, based on the information available at the time

payment rates are set and at the time the assurance is given, it reasonably estimates that its payments will not exceed the upper payment limit.

The new § 447.257 specifies that FFP is not available for State expenditures that are in excess of allowable amounts. A disallowance of FFP because of excess payments will be made if, upon review of State payments, HCFA determines that the State's assurance was either faulty or invalid based on the information that was available to the State at the time it initially gave its assurance. If such a finding is made, then action to recover amounts paid in excess of the Medicare upper payment limit will be taken.

Section 9433 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99-509) enacted on October 21, 1986 amends section 1902 of the Act to prohibit placement of a limitation on the amount of payment adjustments that may be made under a Medicaid State plan with respect to those hospitals that provide services to a "disproportionate number of low income patients with special needs". In effect, this section specifically exempts payments made, in accordance with the requirements of section 1902(a)(13)(A) of the Act, by States to hospitals for care furnished to a disproportionate number of low income patients with special needs from any limits established under Medicaid. Section 9433 of Pub. L. 99-509 is effective retroactively as though it was included in section 2173 of Pub. L. 97-35. We have, therefore, revised the proposed § 447.272 to state that the upper payment limit calculation does not apply to State payment adjustments made to hospitals that provide care and services to a disproportionate number of low income patients with special needs, as described in the State plan. As discussed below, we specifically invite public comment on this change to § 447.272.

*Comment:* One commenter asked which Medicare reasonable cost rules apply to swing-beds and what is the precise methodology by which they are applied.

*Response:* Regulations explaining in detail the Medicare rules applicable to swing-beds are found in §§ 413.114, 413.53(a)(2) and 413.24(d)(5).

*Comment:* One commenter questioned under what circumstances FFP would be denied if a State chose to establish its own rate to reimburse swing-bed hospitals for SNF or ICF services. This commenter also questioned whether there was a separate Medicare upper payment limit for swing-beds.

*Response:* A State setting its own payment rate for swing-beds as allowed by § 447.280(a)(2) is required to meet the same requirements (that is, State plan and payment requirements) as are required for other SNF or ICF services furnished in the State. Thus, if a State fails to meet these requirements, FFP will be denied. There is not a separate Medicare upper payment limit for Medicaid swing-beds.

*Comment:* One commenter stated that the assurances required for States that set their own payment rates for swing-beds is a further burden on small States that have fewer swing-bed patients.

*Response:* Section 447.280 extends rate-setting flexibility to States for swing-bed services in accordance with section 1913(b)(3) of the Act, as enacted by section 2369 of Pub. L. 98-369. However, States are not required to use this flexibility and may choose to provide for payment for swing-beds in accordance with § 447.280(a)(1). This provision allows a State to make payment for these services at the average rate per patient day paid to SNFs or ICFs, other than ICFs/MR, as applicable, for SNF or ICF services furnished during the previous calendar year. A State choosing payment for swing-beds in accordance with § 447.280(a)(1) is not subject to any additional State plan or payment requirements.

*Comment:* Two commenters questioned whether we had considered making a conforming change to § 413.53(a)(2), which defines the carve-out method of determining inpatient routine service costs for swing-bed hospitals under Medicare. These commenters believe that if § 413.53(a)(2) is not amended, the provisions in this section will require hospitals under the Medicare program (or hospitals whose State plan follows Medicare principles of payment in determining inpatient routine service costs for Medicaid purposes) to compute the carve-out for swing-bed days by using the prior year State rate even though the State may have elected to use an alternative rate to pay for Medicaid swing-bed days.

*Response:* We do not believe that a conforming change to § 413.53(a)(2) is necessary. As we explained in the preamble of the interim final rule published on July 20, 1982 (47 FR 31522) that implemented the initial swing-bed legislation, we believe the carve-out method is intended to remove the routine costs of SNF and ICF services furnished by a swing-bed hospital, not the "reimbursement due" to the hospital for these days. Although a hospital can receive different payment amounts for

swing-bed days incurred by private pay patients, Medicare patients and Medicaid patients, the routine costs attributable to these services are the same regardless of whether the patient is a private pay patient, Medicare patient, or Medicaid patient. If actual payment amounts, rather than the costs for SNF and ICF services were subtracted from the hospital's general routine service costs, the remaining amount would not represent the costs attributable to the general routine hospital services. Therefore, in applying the carve-out method, we will continue to subtract the costs attributable to swing-bed days as currently defined in § 413.53(a)(2).

#### IV. Regulatory Impact Statement

Executive Order 12291 requires us to prepare and publish a regulatory impact analysis for any regulations that are likely to have an annual effect on the economy of \$100 million or more, cause a major increase in costs or prices, or meet other threshold criteria that are specified in that order. In addition, we prepare and publish a regulatory flexibility analysis in a manner consistent with the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 through 612) unless the Secretary certifies that the regulations will not have a significant economic impact on a substantial number of small entities. We consider all hospitals and nursing homes to be small entities under the RFA, but States and individuals are not small entities.

In the proposed rule published February 18, 1986, we set forth our reasons for preparing neither an economic impact analysis under E.O. 12291, nor a regulatory flexibility analysis under the RFA. One commenter argued that this was inappropriate.

*Comment:* One State commenter argued that the cumulative percentage reduction of the changes to the upper payment limit could potentially affect Medicaid programs by more than \$100 million. The commenter also argued that HCFA's past practice allowed States to estimate the payments according to the Medicare principles of reimbursement by trending forward Medicaid costs from a base period when costs were still determined by Medicare principles of payment.

*Response:* We do not believe the commenter correctly characterized either the established policy on upper payment limits, or our proposed changes. Certainly, the changes made to the upper payment limit provisions in this final rule, as revised in response to comments received, will not produce a cumulative percentage reduction of

more than \$100 million. As discussed above, the States will continue to be allowed to use Medicare principles of payment to determine their State limits. State-owned hospitals that have different services than private hospitals will prepare a separate set of limits.

As was the case with the proposed rule, we are unable to estimate potential savings from the revised upper payment limit. This final rule may affect States in which State-owned facilities are currently paid at levels that would exceed the limits in one of two ways: the State may revise its payment methodology under its State plan to come into compliance with the upper limit requirements, or it may continue its current payment methodology. In the latter case, the affected State will experience reduced FFP and an increased share of the costs of medical care furnished in the affected facilities. However, because we believe the problem described above is limited to relatively few States, we do not expect either the overall economic impact or the administrative costs to be significant.

We have determined that the other provisions of this final rule would not have a significant economic impact for the reasons set forth in the proposed rule. Therefore, this rule is not a major rule and a regulatory impact analysis is not required. Further, the Secretary certifies that these regulations will not have a significant economic impact on a substantial number of small entities. A regulatory flexibility analysis has not been prepared.

#### V. Other Required Information

##### A. Paperwork Burden

The change we made to § 447.253(b) of this final rule will require the submission by States of additional information required by § 447.255. Consequently, this change is subject to the Office of Management and Budget (OMB) approval under the Paperwork Reduction Act of 1980 (44 U.S.C. 3501-3511). A request for approval of information collection requirements has been submitted by HCFA to OMB. Upon OMB approval, HCFA will publish a notice in the *Federal Register* announcing OMB's approval and displaying the control number assigned by OMB for this information collection requirement. Until that time, this change is not effective. Comments on the collection of information requirements pertaining to this change should be sent to the following address:

Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office

Building (Room 3208), Washington, DC 20503, Attention: HCFA Desk Officer

In addition, we note that the information collection requirements contained in §§ 447.253(a) and 447.255 (to which the former section refers) have previously been reviewed by OMB and approved. Thus we are updating 42 CFR 400.310 to display the valid OMB control number (0938-0193) assigned for the requirements described in §§ 447.253(a) and 447.255.

##### B. Waiver of proposed rulemaking

In section III of this preamble, we noted that section 9433 of Pub. L. 99-509 amended section 1902 of the Act to prohibit the placement of a limitation on the amount of payment adjustments that may be made under a Medicaid State plan with respect to those hospitals that provide services to a "disproportionate number of low income patients with special needs." This provision is effective retroactively as though it had been included in section 2173 of Pub. L. 97-35, which was enacted on August 13, 1981. This legislative change is being implemented in this final rule in § 447.272(c).

Generally, we issue a notice of proposed rulemaking and provide a period for public comment before implementing amendments to the law through regulations. However, we may waive this procedure if it would be impractical, unnecessary, or contrary to the public interest.

In § 447.272(c), we provide that the Medicare upper payment limit does not apply to payment adjustments made under a State plan to hospitals that serve a disproportionate number of low income patients with special needs, as provided for in § 447.253(b)(1)(ii)(A). This exception to the Medicare upper payment limit is merely a conforming change required by section 9433 of Pub. L. 99-509, which, as noted above, is effective retroactively to August 13, 1981.

In view of the retroactive nature of this provision and the fact that it is a conforming change required by the law, we believe that the delay in implementing this provision that would be necessitated by proposed and final rulemaking would be impractical and contrary to public interest. Thus, we find good cause to waive the proposed rulemaking procedures. However, we are providing a 60-day comment period so that interested parties may comment specifically on this provision (that is, § 447.272(c)).

Because of the large number of items of correspondence we normally receive, we cannot acknowledge or respond to

them individually. However, we will consider all comments concerning § 447.272(c) that are received by the date and time specified in the "Dates" section of this preamble. If, as a result of these public comments, we conclude that changes in § 447.272(c) are needed, we will respond to the comments and include the changes in a future Federal Register publication.

All other provisions included in these final regulations were proposed in the NPRM, and we are responding in this document to comments received on these provisions. Therefore, if another Federal Register publication is necessary, we expect to address only comments that concern § 447.272(c).

#### List of Subjects

##### 42 CFR Part 400

Grant programs—Health facilities, Health maintenance organizations (HMOs), Medicaid, Medicare, Reporting and recordkeeping requirements.

##### 42 CFR Part 447

Accounting, Administrative practice and procedure, Grant programs—health, Health facilities, Health professions, Medicaid, Reporting and recordkeeping requirements, Rural areas.

42 CFR Chapter IV is amended as set forth below:

#### CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES

A. Part 400 is amended as follows:

##### PART 400—INTRODUCTION: DEFINITIONS

1. The authority citation for Part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. Chapter 35.

2. Section 400.310 is amended by adding, in numerical order by CFR section, the following entry of the section that provides for collections of information and the assigned OMB control number.

§ 400.310 Display of currently valid OMB control numbers.

Sections in 42 CFR that contain collections of information	Current OMB control numbers
447.253(a).....	0938-0193
447.255 .....	0938-0193

B. Part 447 is amended as follows:

##### PART 447—PAYMENTS FOR SERVICES

##### Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

1. The authority citation for Part 447 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302), unless otherwise noted.

2. The table of contents for Subpart C is amended by adding an undesignated center heading and titles for new §§ 447.257 and 447.272 to read as follows:

##### Subpart C—Payment for Inpatient Hospital and Long-Term Care Facility Services

Sec.

\* \* \* \* \*

##### Federal Financial Participation

§ 447.257 FFP: Conditions relating to institutional reimbursement.

\* \* \* \* \*

§ 447.272 Application of upper payment limits.

\* \* \* \* \*

3. In § 447.253, paragraph (a) is revised, the introductory language of paragraph (b) is revised, the introductory language of paragraph (b)(1)(ii) is republished, and paragraphs (b)(1)(ii)(B) and (b)(2) are revised to read as follows:

##### § 447.253 Other requirements.

(a) *State assurances.* In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payments rates.*

\* \* \* \* \*

(ii) With respect to inpatient hospital services—

\* \* \* \* \*

(B) If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing or intermediate care services) under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify

that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act; and

\* \* \* \* \*

(2) *Upper payment limits.* The agency's proposed payment rate will not exceed the upper payment limits as specified in § 447.272.

\* \* \* \* \*

##### § 447.256 [Amended]

4. In § 447.256, paragraph (a)(1) is revised by deleting the words, "significant or other".

5. A new undesignated center heading and a new § 447.257 are added to read as follows:

##### Federal Financial Participation

##### § 447.257 FFP: Conditions relating to institutional reimbursement.

FFP is not available for a State's expenditures for hospital inpatient or long-term care facility services that are in excess of the amounts allowable under this subpart.

6. A new § 447.272 is added to read as follows:

##### § 447.272 Application of upper payment limits.

(a) *General rule.* Except as provided in paragraph (c) of this section, aggregate payments by an agency to each group of health care facilities (that is, hospitals, SNFs, ICFs, or ICFs for the mentally retarded (ICFs/MR)) may not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles.

(b) *State operated facilities.* In addition to meeting the requirement of paragraph (a) of this section, aggregate payments to each group of State-operated facilities (that is, hospitals, SNFs, ICFs, or ICFs/MR) may not exceed the amount that can reasonably be estimated would have been paid under Medicare payment principles.

(c) *Exception.* The upper payment limitation established under paragraphs (a) and (b) of this section does not apply to payment adjustments made under a State plan to hospitals found to serve a disproportionate number of low income patients with special needs, as provided in § 447.253(b)(1)(ii)(A).

7. Section 447.280 is revised to read as follows:

**§ 447.280 Hospital providers of SNF and ICF services (swing-bed hospitals).**

(a) *General rule.* If the State plan provides for SNF or ICF services furnished by a swing-bed hospital, as specified in §§ 440.40(a) and 440.150(f) of this chapter, the methods and standards used to determine payment rates for routine SNF or ICF services must—

(1) Provide for payment at the average rate per patient day paid to SNFs or ICFs, other than ICFs/MR, as applicable, for routine services furnished during the previous calendar year; or

(2) Meet the State plan and payment requirements described in this subpart, as applicable.

(b) *Application of the rule.* The payment methodology used by a State to set payment rates for routine SNF or ICF services must apply to all swing-bed hospitals in the State.

C. Subpart D is amended as follows:

**Subpart D—Payment Methods for Other Institutional and Noninstitutional Services**

1. Section 447.321 is revised to read as follows:

**§ 447.321 Outpatient hospital services and clinic services: Upper limits of payment.**

(a) *General rule.* FFP is not available for any payment that exceeds the amount that would be payable to

providers under comparable circumstances under Medicare.

(b) *Application of the rule.* Payments by an agency for outpatient hospital services may not exceed the total payments received by all providers from beneficiaries and carriers or intermediaries for providing comparable services under comparable circumstances under Medicare.

(Catalog of Federal Domestic Assistance Programs No. 13.714 Medical Assistance Program)

Dated: April 15, 1987.

**William L. Roper,**  
*Administrator, Health Care Financing Administration.*

Approved: May 1, 1987.

**Otis R. Bowen,**  
*Secretary.*

[FR Doc. 87-17081 Filed 7-27-87; 8:45 am]

BILLING CODE 4120-01-M

**DEPARTMENT OF DEFENSE****48 CFR Part 235****Department of Defense Federal Acquisition Regulation Supplement; Cost Sharing; Correction**

**AGENCY:** Department of Defense (DoD).

**ACTION:** Final rule; correction.

**SUMMARY:** This document corrects a final rule issuing changes to the DoD FAR Supplement with respect to Cost Sharing, which was published in the Federal Register on July 1, 1987 (52 FR 24473). This action is necessary to add text which was omitted.

**FOR FURTHER INFORMATION CONTACT:** Mr. Charles W. Lloyd, Executive Secretary, DAR Council, (202) 697-7266. Charles W. Lloyd,  
*Executive Secretary, Defense Acquisition Regulatory Council.*

Accordingly, the Department of Defense is correcting 48 CFR Part 235 as follows:

**PART 235—RESEARCH AND DEVELOPMENT CONTRACTING**

1. Section 235.003 is amended by adding to paragraph (b)(S-71) paragraph (iv) to read as follows:

**235.003 Policy.**

\* \* \* \* \*

(b)(S-71) \* \* \* \* \*

(iv) When the contractor is an educational institution or nonprofit organization, cost sharing in most cases would not be appropriate in view of their nonprofit status and limited ability to recover cost participation from non-government sources.

\* \* \* \* \*

[FR Doc. 87-17042 Filed 7-27-87; 8:45 am]

BILLING CODE 3810-01-M